THE HEARING GROUP
OF NEW MEXICO

PATIENT INTAKE FORM

Patient Name:_____ **SSN:**_____

DOB:_____ **Age:**_____ **Sex:**_____ **Email:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____ **How did you hear about us:**_____

Best Phone#:_____ **Alternate Phone#:**_____ **Work#:**_____

Primary Dr. Name:_____ **Doctor's Phone #:**_____

ENT Name:_____ **ENT Appt. Date:**_____

Patient/Parent Employer:_____

Parent/Guardian Name:_____ **Contact #:**_____

Emergency Contact Name:_____ **Phone #:**_____

NOTICE OF HEALTH INFORMATION PRACTICES

I have received and reviewed The Hearing Group of New Mexico's Notice of Health Information Practices, which outlines my patient privacy rights and the use of my protected health information as defined in the Health Insurance portability and Accountability Act of 1996, as amended ("HIPAA").

My signature below serves as notice of my receipt of The Hearing Group of New Mexico's Notice of Health Information Practices and will confirm my receipt of the Notice of Health Information Practices throughout my care at The Hearing Group of New Mexico.

I understand that if I have any questions regarding the use of my protected health information or the privacy policy of The Hearing Group of New Mexico, I may contact the organization in writing or by phone at any time to express my questions and concerns.

_____
Signature of Patient or Applicable Guardian

_____
Printed Patient Name

_____
Date